
At the coalface

The student with a writing block – the ethics of psychotherapy

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Editor's note: At the coalface

At the coalface is an intermittent series in which readers relate an ethical dilemma they have experienced themselves in the course of their work with as much or as little analysis as they wish. The journal is keen to publish such reports and any reader wishing to contribute should send his or her paper (500–3500 words) to the Editor, Journal of Medical Ethics, Institute of Medical Ethics, 11-13 Cavendish Square, London W1M 0AN. Contributions can be published anonymously if the writer wishes.

In response to a question from an American reader: The phrase 'at the coalface' is used to designate those who do the actual work of their trade or profession rather than administrators, managers, theorists and advisers. Just as miners in the mining industry are the workers who get the coal, or other substance, from the earth 'at the coalface' so doctors and nurses are among the workers who treat patients at the 'medical coalface'.

Author's abstract

The potential role of the psychotherapist as ethical interventionist is considered with reference to a patient who presented with a writing block. The case for the therapist to act paternalistically is followed by the counterargument which revolves around the respect for autonomy. A bridge between these two opposing positions is then offered which depends on viewing informed consent as a dynamic process. As part of this procedure it is made clear that while autonomy is the desired end-state of psychotherapy, it is not the be all and end all of treatment. Therapy is necessarily value-laden since it aims for the enhancement of the patient's state of autonomy; it is value-free inasmuch as the therapist desists from guiding the patient in how she should live her life.

As a psychiatrist involved in the clinical practice of psychotherapy, I am constantly buffeted by an ethical quandary. Given that psychotherapy is permeated by the need for decisions to be taken by the patient about how he shall live his life, is the role of the therapist not that of 'ethical interventionist', that is, is he not

influenced, overtly or covertly, by the values he espouses and is it not those values which dominate the therapeutic enterprise? The case of Sally highlights particularly well the nature of the problem.

Sally, a 33-year-old post-doctoral student in history, consulted her GP six-months after taking up a prestigious fellowship. She complained of a writing-block: 8 am, a clear sheet of paper, a sharpened pencil – the daily ritual of preparing to convert her doctoral thesis into a book, but words were not forthcoming. Demoralisation had set in; the demoralisation had in turn led to other difficulties. She had been asked to give a paper to a departmental seminar, havered about this relatively minor task for four months, and finally felt quite incapable of doing it. Sally's relationship with her boyfriend had deteriorated badly. As an academic himself he had encountered intermittent writing blocks but had ultimately forced himself into 'getting on with it'; she ought to do the same.

The GP responded to her problem on the premise that it did fall into his professional domain; indeed, he went further by referring her to a psychiatric clinic. Now, we must note the 're-framing' of the problem in the hands of the psychiatrist. The writing block is acknowledged but put in the context of a longstanding 'personality pattern disturbance'. Sally is not inner-directed, but requires a structure in order to function effectively. She only managed in previous academic pursuit by virtue of her interaction with fellow faculty. In her current situation, she is on her own and this has 'underlined her uncertainty about herself'. There is more to it than this: she has been quite depressed at times in the past; she has had a series of failed relationships with men (she soon seeks out their shortcomings and breaks off the tie, disappointed and disillusioned); she has been apt to 'lean' on others, relying on them for guidance, and finally, although she has doggedly pursued an academic career, she has been uncertain about what she wants to do in life.

Thus, the writing block is symptomatic of deep-seated personal problems, and it is these problems that will necessarily become the therapeutic focus.

Sally was in two minds about this re-framing. This was neatly demonstrated in her response to a request for a brief biography ('say three or four pages'). The biography was no less than 28 double-spaced typed

Key words

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pages of brilliant material – no writing block here! She revealed an insightful grasp of the relevance of various aspects of her family history. She rendered the material in such a way as to convey the impression that here was a potential beneficiary of psychoanalytic psychotherapy.

In negotiating a therapeutic programme I took pains to clarify that whilst appreciating the urgency of the writing block, it seemed that exploration of issues *underlying* the block was more likely to exert beneficial effects. In any event, I was not sufficiently equipped to assume the role of 'quasi-tutor'.

Events over the next few weeks indicated that this process of negotiation had not succeeded. Sally saw little point in spending an hour a week over the next year (my recommendation) delving into the past when she had only 18 months of her fellowship left. If I could not help her perhaps one of my colleagues could.

By the fifth session, the discrepancy in the conception of Sally's problems reached a head. She was palpably distressed: the work was going badly, the article she should have completed was 'frozen', she felt under immense pressure from her boyfriend, and she had a pending rendezvous with an old colleague who no doubt would be under the impression that her book was 'well under way'. She desperately needed help to write the paper. Could I refer her to a colleague with expertise in writing block?

Notwithstanding my continuing inclination to regard the problem as surface only, I relented in the face of her pertinacious insistence. Thus it was that a parallel programme of help was instituted, which was to continue for several months. A psychologist began to see her at regular intervals with the explicit purpose of helping her to 'surmount the writing block' while I stuck to my original brief – to get her to understand what lay behind the surface problem.

Obviously, the clinical details are not relevant for my purposes but I provide a summary of the themes so that my ethical dilemma can emerge more concretely.

Sally was the product of a middle-class, WASP (White Anglo Saxon Protestant) American culture. Her family of four (she had a sister one year older) was a model unit of the nuclear family, whose head was undoubtedly her father. He was virtually a caricature of middle-class, suburban values: making money was the central value in his life, and he worked hard to make it. The money seemed to be necessary to confirm his sense of worth. Mother, the daughter of poor migrants, had grown up in mid-Western America acutely aware of her lower class status. Upon meeting her husband-to-be, she was impressed by his determined individualism and his will to succeed. The marriage was patently devoid of intimacy as father remained preoccupied with his monetary goal and mother retreated into friendless insularity.

Sally felt stifled within this milieu, disdainful of her mother for capitulating but ambivalent towards her father, admiring his individualism on the one hand but resenting his emotional inaccessibility on the other

hand.

There was no place or time for affection and sentiment. The girls should in essence become 'doers', much like himself, and affirm themselves by accomplishment. Sally's sister had clearly escaped these expectations. She had married early, produced two children, and was happily settled in a small community, at a safe distance, both geographically and emotionally, from father's leverage.

Sally, by contrast, was trapped by her need to prove to her father that she was a successful achiever, and thereby gain his approval. So, it became explicable that, despite being an average student, she had from an early age struggled to shine, whether in the class-room, at the piano or in the cheer-leading squad. As the years passed she predictably transferred her desperate need for father's approval to other older men, particularly esteemed teachers. Quite unconsciously, she had elected to prove her worth via the academic route. But this was done in a particular way. Not the local state university, but an Ivy League College; not content with a Bachelor's degree, but completing a doctoral thesis, and then at one of the most reputable American universities; and finally, not satisfied with a 'humble' lectureship at a provincial university she successfully applied for a prestigious post-doctoral fellowship in order to write the 'definitive' work on her specialist topic.

Throughout this *rite de passage*, she struggled intellectually, haunted by self-doubt, and repeatedly sought out older male Faculty as sources of support. It was also these figures she felt an overwhelming need to please. Classical father-substitutes!

As the months rolled by, and her self-understanding grew, she could see that her academic ambitions were inextricably bound up with the family dynamics spelled out above. But, she had progressed minimally with her writing. Although the psychologist saw 'evidence of structure and a clear line of argument' in her later writing, the book itself had been likened by Sally to an 'albatross'.

The central question stared us in the face. Should she persevere with what seemed to be a futile task or abandon the project, at least for the time-being? This choice caused her no end of grief. She was immobilised. The last few months of therapy (it lasted 18 months and ended with Sally's departure for home upon completion of her fellowship) were consumed by the above conflict and her efforts to clarify her underlying motivations and feelings. It was a tortuous pursuit, accompanied by anguish and perplexity. By the end of treatment, she was indubitably more insightful, but still agonising over the blank pages and unable to come to terms with the reality of what she perceived as her 'failure'.

The therapist as 'ethical interventionist'

The most taxing matter for me once Sally embarked on therapy revolved around the question of the legitimacy or otherwise of my role as a moral agent. Although the

chief focus remained the 'book', therapy threw up the broader question of what unconscious factors were motivating her – academically, interpersonally, and more generally, in the decisions she took about how to live her life. The therapeutic work demonstrated how muddled were her motivations, not only *vis-a-vis* the writing of the book, but also in the case of virtually all her pursuits. She had apparently lived inauthentically, lost sight of her 'true self'. Was this not the opportunity to ditch this inauthenticity and seek self-fulfilment more genuinely? Might she not therefore liberate herself symbolically by dumping the book? Ineluctably, she turned to me, as another father-substitute, for guidance. Usually, I would strive to assume a neutral position in these circumstances, guided by the principle of *respect for autonomy*. I would work on the premise that Sally – with her increasing self-understanding – should be in a position to reflect about her interests, and come to decisions as a result, followed by corresponding action. But, I had to be aware of two issues. Yes, she was considerably more insightful but her well-entrenched pattern of turning to male authority figures had not shifted. Also, I was preoccupied about what I regarded as a central question: whether to live an authentic life was of greater value than writing a book for the 'wrong' motive, namely to please father. The ethical quandary was thus how to deal with internal pressures, stemming from my own personal value system, and external pressures, as reflected in Sally's constant appeal for guidance.

An attempted analysis

The analysis revolves around a pivotal question: as a mental health expert, was I entitled, indeed *obligated*, to guide Sally into realising the unsoundness of the underlying motivations that influenced her decisions and then to offer her implicitly or explicitly a new, more 'healthy' basis upon which to make such decisions. In all likelihood, the result would be her submission to my *paternalistic* position, and to her taking certain decisions which accorded with my value preferences. Or, on the contrary, was I obligated to remain strictly neutral and submit myself to the principle of *respect for her autonomy*, even though her capacity for autonomous functioning might be impaired as a consequence of her perplexity, demoralisation, and 'selective inattention' (a concept of H S Sullivan, referring to unconsciously-derived suppression of unpalatable thoughts and findings).

The case for paternalism

Let me spell out the case for *paternalism* (or *beneficence* that does not respect autonomy) first (1). The patient seeks help in circumstances where her distress and perplexity has made it impossible for her to reflect clearly about what is in her interests. The result is predictable: impaired functioning, the inability to make reasonable decisions which would promote her welfare.

In other words, the patient is unable to function

altogether autonomously, she cannot fully enjoy the capacity to reflect, and to decide, and to act on the basis of her reflections. The therapist is, in these circumstances, duty-bound to intervene. After all, he is able by virtue of his professional role to remain emotionally detached and thus adopt an objective perspective about what constitutes his patient's best interests. Such a role is echoed in Freud's (2) comment in his essay *Analysis Terminable and Interminable*: '(the analyst) must possess some kind of superiority, so that in certain analytic situations he can act as a model for his patient and in others as a teacher'. One could go even further than model and teacher and argue that the therapist must on some occasions assume a distinctly parental role by steering the patient out of her confused, blocked or self-defeating position. Since she lacks the wherewithal to accomplish this, it behooves the therapist as expert caregiver to do it for her. Once the desired result is achieved, the therapist retreats and hands back the reins to the patient.

There is a significant *caveat* in the therapist assuming this parental role, ie his vulnerability to losing the desired objectivity and either knowingly or (more likely) unconsciously guiding the patient not in terms of what are her best interests but on the basis of his own preferred values. Thus, in Sally's case he might be influenced by his investment in matters academic. In my own case, having worked in an academic environment throughout my professional life, I have always valued scholarship. I could easily tend to regard Sally's abandonment of her project as a misfortune, especially since she had by all accounts written an interesting doctoral thesis; it should, desirably, be converted into a book and thus become available to a wider readership.

The paternalist would argue however that this *caveat* is manageable. The realisation in the therapist that he is a potential victim of subjective preferences, makes him all the more vigilant and observant of his therapeutic contribution. Moreover, he is sensitive to his own values and monitors his impulse to influence the patient in ways which have little or nothing to do with her objective needs.

The case for respect for autonomy

The chief counterargument rests on the principle of *respect for autonomy*. Whatever the emotional state of the patient, she is seen as autonomous in terms of her capacity to be reflective (3). The therapist's job is confined to that of *facilitator*, in a process in which the patient sets her own therapeutic goals. The doyen of this approach, Carl Rogers, (4) thus labels his brand of psychotherapy as '*client-centred*' and asserts that: 'one of the cardinal principles in client-centred therapy is that the individual must be helped to work out his *own* value system...'.

Any deviation from this position is regarded as a slippery slope in which the patient is robbed of the responsibility of grappling with her difficulties, with the obvious corollary of an undermining of autonomy.

Even a tendency in the therapist to exceed his facilitatory function is deemed undesirable since it paves the way for a collusive pact, whereby the patient's propensity to regress, and the therapist's proclivity to 'parentify', are fostered. Such a development constitutes a disservice to the patient and is unwarranted both clinically and ethically.

The therapist's obligation, on the contrary, is to promote his patient's autonomy as a desirable goal in itself. In a patient like Sally, heteronymy has prevailed for too long and in a self-defeating way. She has always been overly influenced by this and consequently assumed a passive, compliant role in her interaction with others. It is this heteronymous state which has led in large measure to so much anguish and difficulty.

An ambiguity creeps into the argument but one which the proponent of a respect for autonomy takes account of. The fact that a patient has acted heteronymously in the past does not negate the possibility that she has the capacity to be self-determining in the present and in the future, provided certain conditions are satisfied. The premise upon which the therapist operates is as follows: the patient deemed to be suitable for analytic psychotherapy (whose chief objective is greater self-knowledge, paving the way for clearer and thus more rational decision-making) has lost, in some measure, the capacity to be a self-determining agent as a result of the influence of unconscious factors. These factors are recoverable, identifiable and ultimately understandable through the psychoanalytic process; and once within the patient's intellectual grasp, she is no longer constrained but able to reflect freely and rationally about what constitutes her best interests.

Moreover, therapy itself serves as an optimal forum for the procedure to operate since the patient is made aware that she will be required to assume responsibility for the work involved whereas the therapist's job will be confined to facilitator.

A bridge?

In considering paternalism and respect for autonomy as contradictory positions, I have alluded to some of the limitations inherent in each. Let me summarise what I regard as the chief problems:

The paternalist, no matter how well intentioned in working towards the objective of promoting his patient's autonomy, does so at the significant risk of imposing his own values. Given that therapy involves considerable decision-making about how a patient chooses to live her life, the therapist's authority (whether deserved or not) will inevitably have an immense influence on how such choices are made. Thus, the danger is that psychotherapy becomes a process of indoctrination in which the hapless patient compliantly submits to the expert. Instead of achieving self-governing status by the end of treatment, she has become even more heteronymous than she was before entering it. A disservice has been done.

The argument for respect for autonomy rests unconvincingly on the premise that the patient bears a capacity to be completely autonomous within treatment itself. This does not square with the customary clinical situation: the patient, and Sally exemplifies this well, is in a demoralised state, oppressed by confusion, anguish and a host of other debilitating experiences which preclude the ability for clear self-reflection and decision-making. There is something of a paradox here – the wish to respect an autonomy which is inadequate, in at least the sense that the patient is thoroughly perplexed and thus incapable of rational thinking. (We need to add a crucial point here, namely that the patient may well be, is likely to be, quite competent in many other respects, but not adequately so concerning the problem areas which have led to the need for help.) The danger of such a pursuit is that the patient slips further into a quagmire of helplessness and hopelessness. Again, a disservice has been done.

What is the remedy? To consider the issues of *time* and *informed consent* (5); they are actually intertwined but let me treat them separately for heuristic purposes. Take *time* first. Psychotherapy is an evolutionary process which takes place over time, at least over several weeks and more customarily over months or years (Sally's treatment lasted 18 months). During this period, the nature of the therapist-patient relationship necessarily undergoes a series of transformations, dependent upon the psychological state of the patient and the objectives of the therapist.

The principal objective at the outset and throughout treatment remains self-governing status, whereby the patient is unfettered from unconsciously-derived neurotic influences. But, during the pursuit of this objective, the therapist will in all likelihood be required to influence his patient as she grapples with the task. Because of her psychological condition, she lacks the wherewithal to be adequately autonomous at all times. There will be occasions when her efforts to be introspective result in perplexity and/or distress, either of which hinder such that the authority of the therapist is legitimately called for if the patient is not to deteriorate (6). The therapeutic enterprise is potent, and therefore for good or for ill. So, whilst autonomy is the sought-for end-state, it is not the be all and end all of treatment.

Informed consent is most relevant in this context. The therapist apprises his patient about the nature of the task and the corresponding features of their working relationship. The goals of treatment, and the means whereby they will be striven for, are carefully spelt out. Similarly, the responsibilities and tasks of both partners are identified (7). Whatever the patient's initial clinical condition, the process itself of obtaining such informed consent must be rigorous and painstaking in order that she will appreciate the *modus operandi*, and know more or less (this cannot be specified precisely) what to expect.

As part of the procedure, it is necessarily emphasised that the patient's autonomy is the desired end-state since this will permit her to regain (or gain for the first time) the management of her own life. This also permits the therapist to understand and to accept that his task ends when such self-management is attained, and does not entail the imposing of his views on how that life should be lived. Informed consent of this type also serves the therapist's needs as he realises explicitly that he is also consenting to a procedure which involves specific roles and tasks for himself. The origin of the term – *con-sentire* – to feel with – encapsulates rather neatly the spirit of the process (for this is indeed what it is, as opposed to a static, legalistic document), one in which both protagonists are jointly committed and motivated. Furthermore, this conjoint quality typifies the therapeutic endeavour which follows.

The permeation of therapy by values

Notwithstanding the utility of informed consent, the inevitable *permeation of treatment by values* needs to be reckoned with by the therapist. At a fundamental level it is inescapably the case that construing a patient's problems as reflecting diminished autonomy, that is inadequate autonomy with respect to the problems that have made therapy necessary, constitutes a value in itself. In effect, the therapist is incorporating a basic 'ought' dimension into his encounter with the patient: 'Therapy will be successful as a function of how effective you are in achieving or re-achieving full autonomy'. Or to put it in terms derived from the approach of Beauchamp and Childress (8): 'You will be in a position to determine your own course of action which accords with a plan chosen by yourself. So, you will be free to deliberate about and choose plans, and also be able to act on such deliberations and choices'.

The therapist is necessarily inculcating and promoting values such as self-reliance and self-determination. Above all, he is offering the patient a value-bound explanation of the nature of neurosis and its corresponding remedy. Thus, as we saw at the beginning of this analysis, the neurotic patient is hampered and baffled by psychological forces of which she is unaware (3). Identifying and making sense of these forces leads to the diminution or removal of the hindrance; the patient is then free and able to live her life more effectively.

The thorny question of *how* the patient should live her life still remains. Is this the business of the therapist? Logically this cannot be so if the desired end-state is autonomy; the patient is now free to deliberate, choose and act and the therapist is obliged to respect that autonomy without reservation.

Engelhardt (9) has conceptualised this issue usefully by referring to psychotherapy as an example of *meta-ethics*. The therapist provides those conditions whereby his patient will achieve personal autonomy, and once in that state, make ethical choices; he does not proffer his own ethic and thus desists from giving particular advice or making particular suggestions.

Thus, therapy limits itself to preparing the ground – through the patient 'integrating (her) mental life and coming to terms with (her) impulses and (her) external environment', – in order that she is better placed (not necessarily optimally placed – this is not always feasible) to make ethical choices at its conclusion and thereafter.

Caveats for the therapist

This meta-ethical approach appears sound but is it feasible? There is little doubt that principle is one thing, its implementation quite another.

No matter how diligent the therapist is in confining himself to the 'autonomy' objective, he will be buffeted by forces, usually unconscious in origin (ironically, the very forces he is helping the patient to identify and deal with), that influence his own judgements. Thus psychotherapy as 'meta-ethical' may slide into psychotherapy as 'ethical'.

Two options are available in dealing with this propensity, but they are not necessarily contradictory. The first could be conveniently termed 'the therapist as "value-monitor"'. He assumes responsibility for being aware of his potential role as 'ethical interventionist', and strives not to impose this burden on (or even share it with) the patient. Intrinsic to this process is a vigilant sensitivity to his own values lest they unwittingly intrude, and to any acceptance of values which his patient may project onto him. This self-monitoring is akin to another essential and well-established task, that of managing countertransference in which the therapist observes closely and consistently his own reactions to the patient. This enables him to detect any harboured attitudes, thoughts and feelings which are either entirely personal and have nothing to do with the patient, or are relevant to the clinical encounter but whose expression is bound to offend or harm.

The second option is for the therapist to divulge aspects of his value system to the patient as a value in itself. In other words, he regards it as ethically desirable to act honestly and genuinely. This position is based on the premise that since psychotherapy is inherently a means of social influence and the therapist has considerably greater power to exert such influence on his patient than the other way around, he acknowledges this imbalance as part of the process of informed consent; and he is subsequently open about the values he espouses.

Several examples come to mind. South African therapists working in the context of a State of Emergency with the victims of State repression (for example persons held in detention and/or tortured) declare their affinity with their patients (10). When apposite, they divulge their own views about racism and injustices perpetrated by the State. 'Gay' therapists proclaim their own sexual affiliation in order to serve a particular constituency, namely homosexual patients struggling to cope with society's ridicule of, and prejudice towards, them (11). These therapists assert that their homosexual patients' problems are

attributable to societal ills; therefore, an understanding of this state of affairs is essential as a therapeutic aim. US veterans of the Vietnam war who have failed to adjust to American society are deemed to be victims of the experience of participating in an unjust war with consequent perplexity, guilt, anger and torment (12). The therapist reveals his affinity with their plight by virtue of avowed political and ethical sympathies and corresponding preparedness to act on the veteran's behalf.

In these illustrations, particular groups of patients are identified with by an ethically committed therapist. But this sort of position may apply more generally. A therapist may wish to disclose certain values he espouses as an ingredient of his therapeutic approach, this on the premise that values are relevant to *all* social encounters and therefore to the therapist-patient relationship.

I suggested earlier that 'value-testing' and 'value-disclosure' are not necessarily contradictory options. A third position combines both options, albeit in a complicated way. The therapist, in accepting that values are integral to the therapeutic process, takes exceptional care to differentiate between those values which are entirely personal to himself and bear no relevance to the patient, and other values which are clearly crucial in the patient's efforts to achieve a more effective degree of autonomy.

Thus, in Sally's case, my own attitudes to academic pursuit, the writing of books, the issue of what constitutes authentic living, and the like, are not pertinent to treatment. They are however the agenda for Sally to wrestle with as she explores unconscious motivating forces that have hindered her so profoundly. On the other hand, I am obliged to stress my conviction to Sally that it is a necessary feature of treatment that she consider participating in an exploratory process whose objective is more enhanced

autonomous functioning. This I clarify in the framework of obtaining informed consent at the outset but reiterate in the course of treatment whenever it is apposite. In this way, the purposes and practice of therapy are always available for scrutiny and appraisal.

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